



# SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

## Using Data to Improve Care

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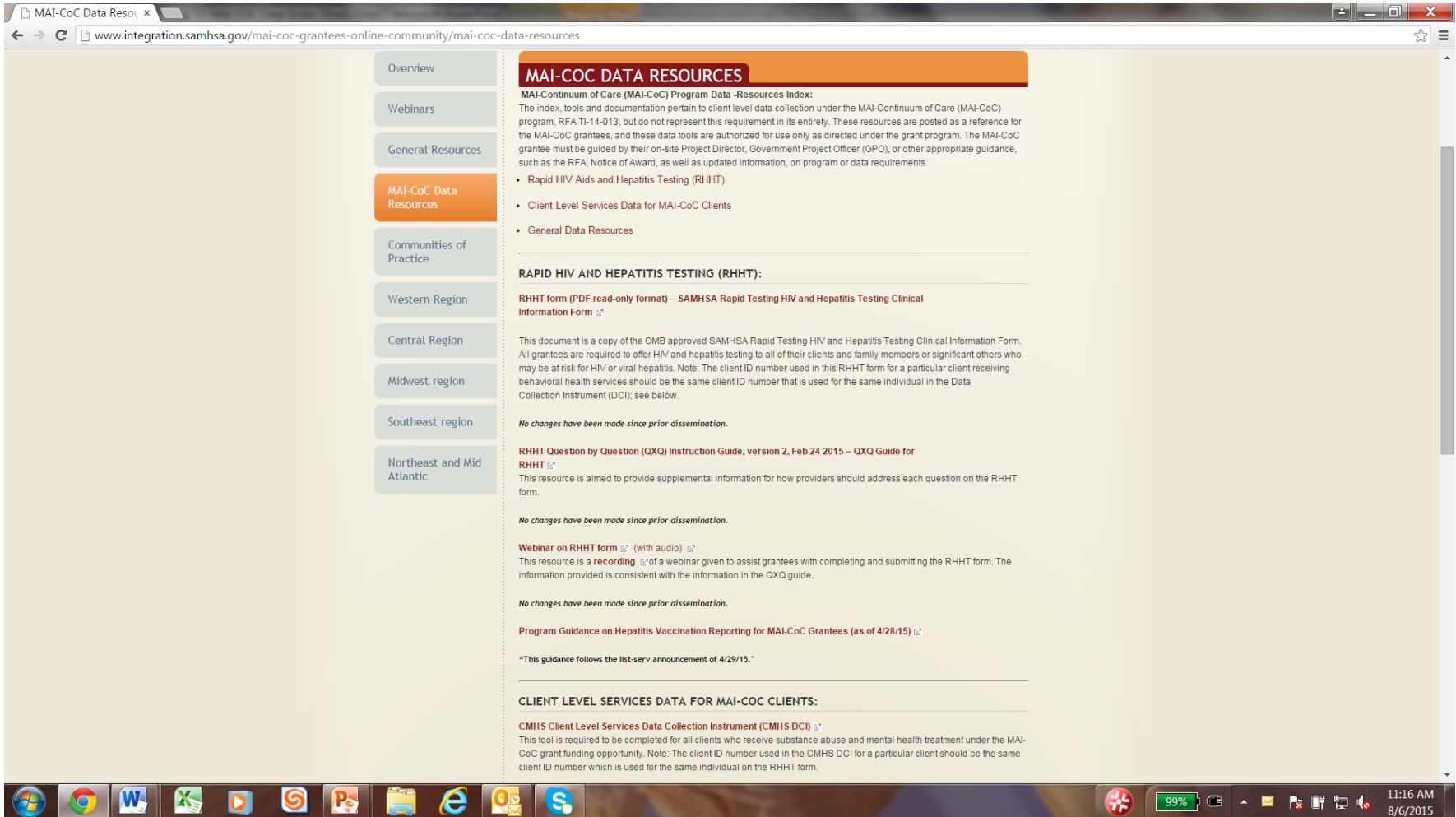
# Agenda

- Identifying target audiences of data
- Understanding methods to move information from aggregate to granular level (and vice-versa)
- Incorporating project dashboards and consumer wellness reports into continuous quality improvement (CQI)

# Group Discussion

- Which staff in your organization care about project data?
- What specific information are they interested in?
- Is the data they are interested in aligned with MAI-CoC data collection requirements?
- Why are they interested in this data?

# MAI-CoC Data Resources Tab at *integration.samhsa.gov*



The screenshot shows a web browser window with the URL [www.integration.samhsa.gov/mai-coc-grantees-online-community/mai-coc-data-resources](http://www.integration.samhsa.gov/mai-coc-grantees-online-community/mai-coc-data-resources). The page features a sidebar with navigation links: Overview, Webinars, General Resources, MAI-CoC Data Resources (highlighted), Communities of Practice, Western Region, Central Region, Midwest region, Southeast region, and Northeast and Mid Atlantic. The main content area is titled "MAI-COC DATA RESOURCES" and includes a "MAI-Continuum of Care (MAI-CoC) Program Data -Resources Index:" section. This section explains that the index, tools, and documentation pertain to client level data collection under the MAI-Continuum of Care (MAI-CoC) program, RFA TI-14-013, but do not represent this requirement in its entirety. These resources are posted as a reference for the MAI-CoC grantees, and these data tools are authorized for use only as directed under the grant program. The MAI-CoC grantee must be guided by their on-site Project Director, Government Project Officer (GPO), or other appropriate guidance, such as the RFA, Notice of Award, as well as updated information, on program or data requirements.

- [Rapid HIV Aids and Hepatitis Testing \(RHHT\)](#)
- [Client Level Services Data for MAI-CoC Clients](#)
- [General Data Resources](#)

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**RAPID HIV AND HEPATITIS TESTING (RHHT):**

**RHHT form (PDF read-only format) – SAMHSA Rapid Testing HIV and Hepatitis Testing Clinical Information Form** [↗](#)

This document is a copy of the OMB approved SAMHSA Rapid Testing HIV and Hepatitis Testing Clinical Information Form. All grantees are required to offer HIV and hepatitis testing to all of their clients and family members or significant others who may be at risk for HIV or viral hepatitis. Note: The client ID number used in this RHHT form for a particular client receiving behavioral health services should be the same client ID number that is used for the same individual in the Data Collection Instrument (DCI); see below.

*No changes have been made since prior dissemination.*

**RHHT Question by Question (QXQ) Instruction Guide, version 2, Feb 24 2015 – QXQ Guide for RHHT** [↗](#)

This resource is aimed to provide supplemental information for how providers should address each question on the RHHT form.

*No changes have been made since prior dissemination.*

**Webinar on RHHT form** [↗](#) (with audio) [↗](#)

This resource is a **recording** [↗](#) of a webinar given to assist grantees with completing and submitting the RHHT form. The information provided is consistent with the information in the QXQ guide.

*No changes have been made since prior dissemination.*

**Program Guidance on Hepatitis Vaccination Reporting for MAI-CoC Grantees (as of 4/28/15)** [↗](#)

*"This guidance follows the list-serv announcement of 4/29/15."*

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**CLIENT LEVEL SERVICES DATA FOR MAI-COC CLIENTS:**

**CMHS Client Level Services Data Collection Instrument (CMHS DCI)** [↗](#)

This tool is required to be completed for all clients who receive substance abuse and mental health treatment under the MAI-CoC grant funding opportunity. Note: The client ID number used in the CMHS DCI for a particular client should be the same client ID number which is used for the same individual on the RHHT form.

# Reporting for External Funders, Board of Directors, Administrators

They want to see....

- Cost savings
- Health improvement



# COST SAVINGS

(YEAR ONE)

Missouri Health Homes have saved **\$30,996,642.**

REDUCTION IN  
HOSPITALIZATIONS  
IN THE FIRST YEAR



**9.1%**

(CMHC HEALTH HOME CLIENTS)

# DIABETES

3-YEAR OUTCOMES  
(FEB 2012 - JAN 2015)

Good Cholesterol

 **37%**

Normal Blood Pressure

 **42%**

Normal Blood Sugar

 **46%**

# HYPERTENSION & CARDIOVASCULAR DISEASE

3-YEAR OUTCOMES  
(FEB 2012 - JAN 2015)

Good Cholesterol  
(Clients with CVD)

 **34%**

Normal Blood Pressure  
(Clients with HTN)

 **41%**

# Reporting for Program Administrators

They want to see....

- Enrollment rates
- Screening rates
- Prevalence of risk factors
- Risk factor improvement rates  
(consider disparities!)
- Grant requirements



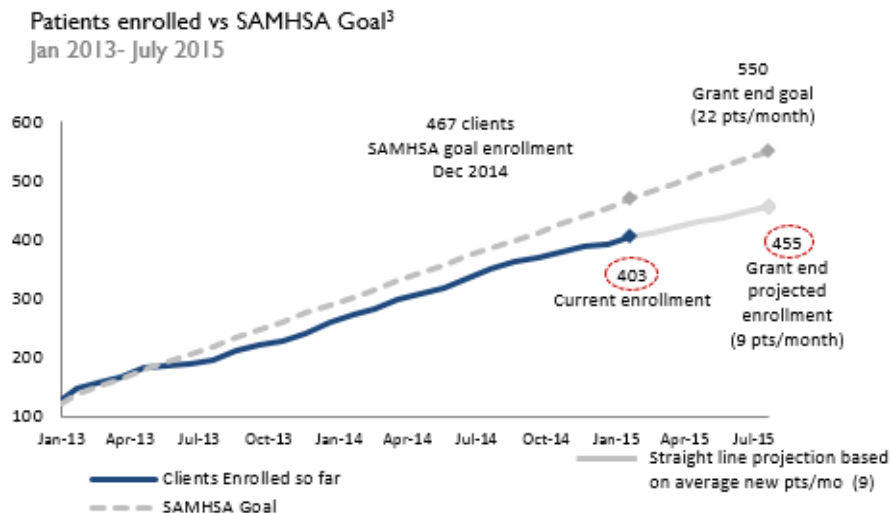


# South of Market Mental Health Primary Care Clinic

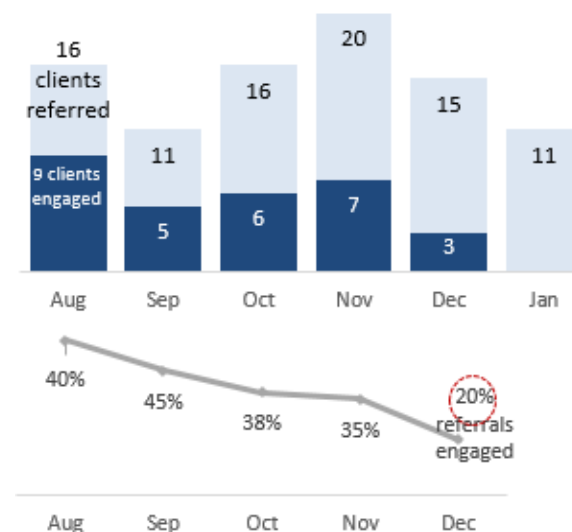
## Process Dashboard, January 31st 2015

**403**  
total clients enrolled

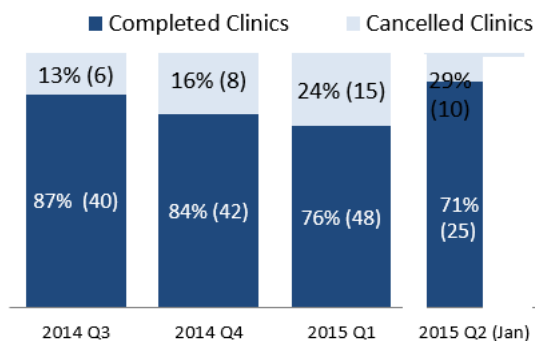
**68%**  
active clients  
273 active, 130 discharged



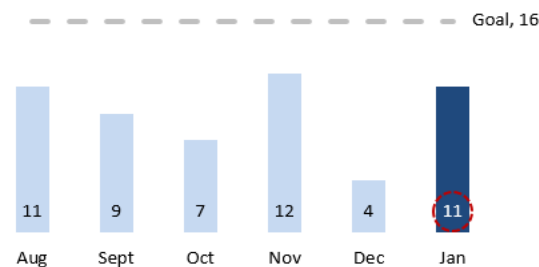
Engagement rate & Referral count  
Jun - Dec 2014



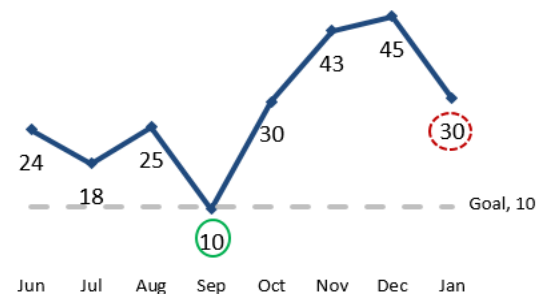
Completed vs. Cancelled Clinics



New Primary Care patients  
July - Jan 2014



Days to first appointment, new clients<sup>6</sup>  
May - Jan 2014



○ = area of success  
○ = area of concern

MONTHLY  
GOAL

15

NEW PATIENT  
REFERRAL

JUNE

14

New Patients

REFERRALS

MADE

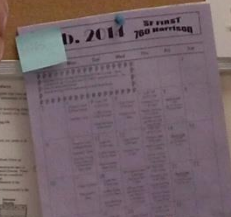
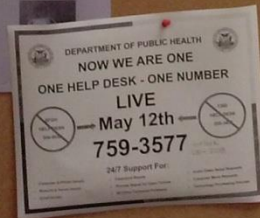
18

NEW  
PATIENTS

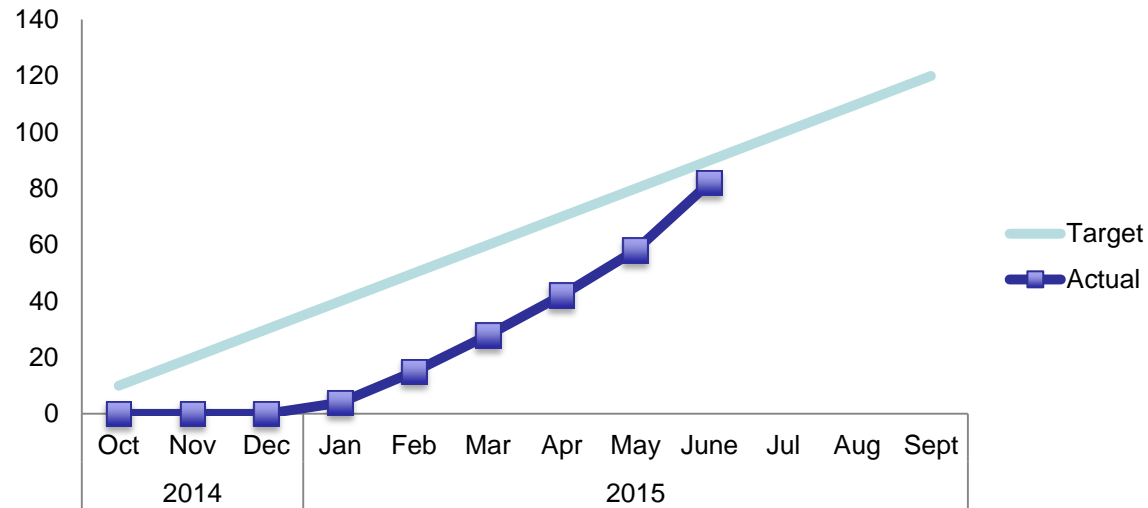
MAY

12

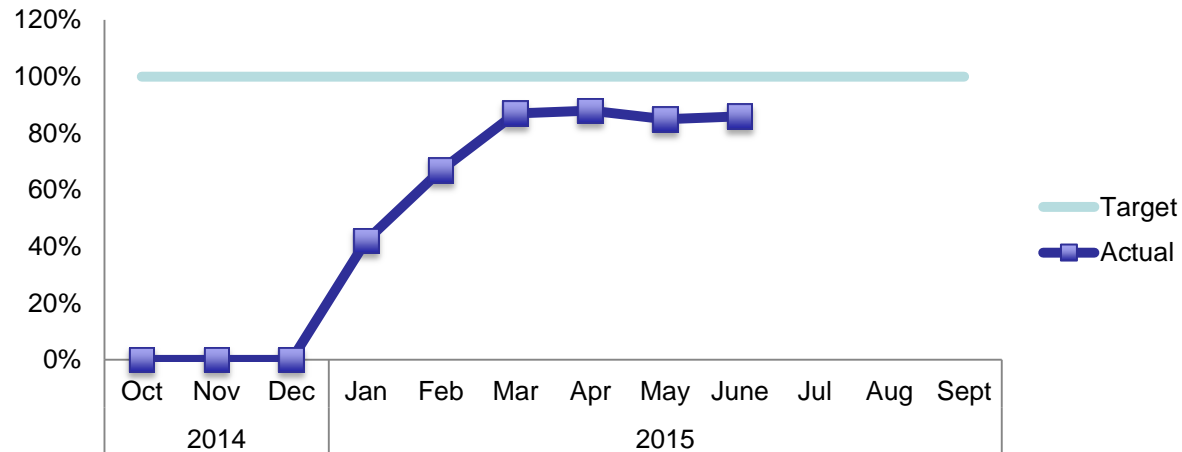
New Patients



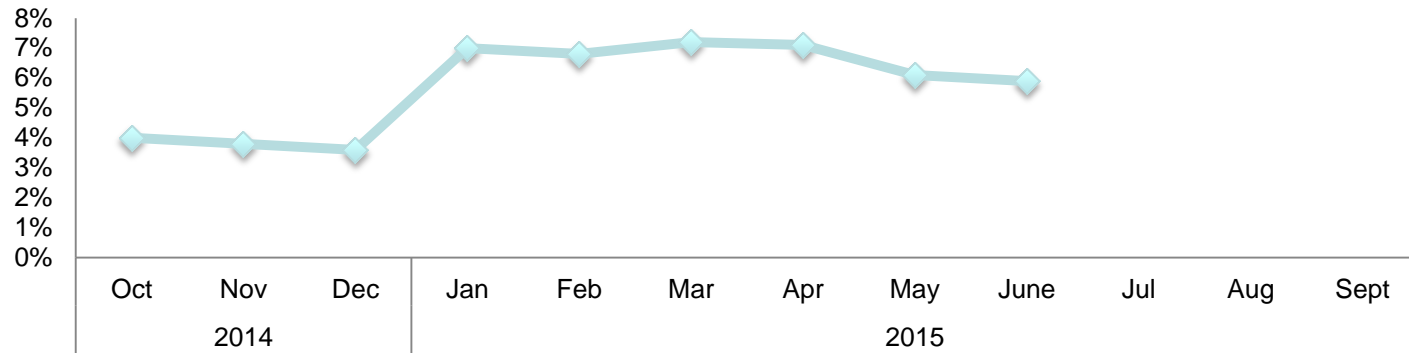
## MAI-CoC Enrollment: Actual vs Target



## Percent of People with Positive HIV Screens Who Were Prescribed ART - Actual vs Target



# HIV Survivorship Rate: Deaths From Complications Related to AIDS over Last 12 Months / Open Cases of People Who Are HIV+ In Last 12 Months



# Group Discussion

- What do you want on your program dashboard?
- How does it align with grant data collection requirements?
- What data exceeds grant requirements?
- Why is this data important?
- Who needs to view this dashboard?
- How can you use it to track progress?

# Reporting for Consumers

They want to see....

- Health status
- Person-centered plan target metrics
- Crisis plan
- Healthcare coordination



# Glenn County Health Care Collaborative

## INDIVIDUAL WELLNESS REPORT

Name: **Bea Well**  
 Clinician: **John Smith**  
 Case Manager: **Jane Doe**



Normal\*  
 Caution  
 At Risk

### Progress on Key Health Indicators

| Category       | Indicator (Goal)            | Baseline<br><i>August 2011</i> | 6-Month<br>Reassessment<br><i>February 2012</i> | 12-Month<br>Reassessment<br><i>July 2012</i> |
|----------------|-----------------------------|--------------------------------|---|--|
| Lungs          | Breath CO (0-6)             | 25                             | 8   | 5  |
| Weight         | BMI (18.5-24.9)             | 25.8                           | 28.1  | 25.3   |
|                | Weight                      | 162.0                          | 174.0   | 158.0  |
|                | Waist Circumference         | 35.5                           | 31.5  | 32.2   |
| Blood Pressure | Systolic BP (90-140)        | 133                            | 135   | 114  |
|                | Diastolic BP (60-90)        | 80                             | 75  | 80   |
| Blood Sugar    | Fasting Glucose (70-99)     | 115                            | -   | 115  |
|                | Hemoglobin A1C (4.0-5.6)    | 5.4                            | -   | 5.4  |
| Heart Health   | Total Cholesterol (125-200) | 197                            | -   | 189  |
|                | LDL Cholesterol (20-129)    | 111                            | -   | 103  |
|                | HDL Cholesterol (40+)       | 76                             | -   | 73   |
|                | Triglycerides (30-149)      | 52                             | -   | 64   |

### Client Wellness Goal(s):

Bea Well will lose 5 pounds within 6 months.

Bea Well will maintain her excellent progress in reducing/stopping her tobacco use.

### Client Mental Health Goal(s):

Bea Well will sleep at least 7 hours each night to decrease symptoms of depression.

### Action Step(s):

Bea Well will walk for 20 minutes five days per week.

Bea Well will eat at least 3 servings of vegetables every day.

Bea Well will go to bed by 10 pm at least 5 nights per week.

Client Signature: Bea Well Staff Signature: John Smith Date: 9/15/2012

# Group Discussion

- What do you want on your individual wellness reports?
- How does it align with grant data collection requirements?
- Why is this data important?
- Who needs to view it?
- How can you use it to track progress?



# Sources for Data Elements

- Centers for Medicaid and Medicare Services
- National Committee for Quality Assurance
- AHRQ
- Institute for Healthcare Improvement
- Grant requirements
- Finance department
- Your peers

# Data Visualization Resources

- Stephanie Evergreen – [stephanieevergreen.com](http://stephanieevergreen.com)
- Edward Tufte – [edwardtufte.com](http://edwardtufte.com)
- American Evaluation Association – [comm.eval.org/DataVisualizationandReporting/home](http://comm.eval.org/DataVisualizationandReporting/home)
- Data Fluency: Empowering Your Organization with Effective Data communication by Gemingnani

# Any Final Questions?

